STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	09/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROWN SENIOR LIVING	7960 SHADELAND AVENUE NORTH INDIANAPOLIS, IN 46250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R000000	This visit was for an Initial State Licensure Survey. Survey Dates: September 17 & 18, 2014. Facility Number: 013328 Provider Number: 013328 AIM Number: N/A Survey Team: Tom Stauss, RN TC Beth Walsh, RN Karina Gates, Generalist Census Bed Type: Residential: 9 Total: 9 Census Payor Type Other: 9 Total: 9 These state findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on September 23, 2014 by Cheryl Fielden, RN.	R000000	The preparation and/or execution of this plan does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies This plan of correction is prepared and/or executed because it is required for the reviewing agency.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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R000091	410 IAC 16.2-5-1.3(h)(1-4) Administration and Management - Noncompliance (h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request. Based on interview and record review, the facility failed to obtain a monthly weight, as ordered and per facility policy, for 1 of 5 residents reviewed. (Resident #1) Findings include: The clinical record for Resident #1 was reviewed on 9/17/14 at 10:30 a.m. The diagnoses for Resident #1 included, but were not limited to, dementia. The September, 2014 Physician's Orders for Resident #1 indicated, "Vital signs & weights: Check & record monthly" effective 6/27/14. The 2014 Monthly Vital Sign and Weight	R000091	Resident #1 had a September weight that did not indicate any weight loss All resident records to include the service plan will be reviewed to ensure that they have current weights recorded as per policy and physicians orders Policy states that residents are weighed once a month and the weight is to be recorded on the Vital Sign Flow Sheet Nursing staff will be educated on the policy and procedure for obtaining weights on residents by the Wellness Director or designee After education is complete, any staff who do not follow the policy for this process will have one-on-one education and counseling as needed The Wellness Director or designee will review all residents weights and weight orders at least weekly for 6 months for compliance Threshold for compliance is 95%	10/18/2014

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	Record for Resident #1 did not indicate an August weight. An interview was conducted with the DON (Director of Nursing) on 9/17/14 at 1:40 p.m., regarding an August weight for Resident #1. She reviewed Resident #1's Monthly Vital Sign and Weight Record and indicated, "No, there's no August weight. I'm not sure if she was weighed in August. Whoever weighs, should have documented on this record." An interview was conducted with the DON on 9/18/14 at 10:28 a.m. She indicated, "There is no August (2014) weight for (name of Resident #1)." The Physician Orders policy was provided by the DON on 9/18/14 at 2:49 p.m. It indicated, "All medications, diets, medical procedures, consultations, and treatments are initiated and monitored by the wellness director, the wellness nurse, or by other licensed health care professionals under the verbal and/or written order of the resident physician."		accuracy If this Threshold is not met after 6 months than continued weekly monitoring will occur This system will be reviewed thru the Quality Assurance process on an on-going basis	
R000216	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following:			

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	(1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on observation, interview, and record review, the facility failed to ensure a residents' weights were recorded on admission. This affected 2 of 7 resident's reviewed for admission weight. (Resident #'s 2, 4) Findings include: 1) Resident #2's record was reviewed on 9/17/14 at 11:44 a.m. The resident's diagnoses included, but were not limited to, congestive heart failure and diabetes mellitus. On 9/17/14 at 1:22 p.m., during an observation, Resident #2 was in his room in his wheelchair working on his computer. He was alert, pleasant, and in no distress. On 9/17/14 at 1:24 p.m., during an interview, Resident #2 indicated he had not been weighed since arriving to the facility due to the facility scale being	R000216	Resident #2 and #4 have had a monthly weight. There is no indication of any medical concerns based on this information All residents weights were reviewed to include their service plan to ensure that an admission weight was obtained A new scale is in place within the community Nursing staff will be educated on the policy and procedure for obtaining weights on residents by the Wellness Director or designee After education is complete, any staff who do not follow the policy for this process will have one on one education and counseling as needed The Wellness Director or designee will review all residents weights and weight orders at least weekly for 6 months for compliance Threshold for compliance is 95% accuracy If this threshold is not met after 6 months than continued monitoring will occur This system will be reviewed through the Quality Assurance process on an on-going basis	10/18/2014

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	broken. On 9/18/14 at 10:04 a.m., the Wellness Director (WD) indicated Resident #2 had no weights recorded for him, including an admission weight, since he arrived as a resident to the facility. She indicated an admission weight should have been obtained for Resident #2, but the electronic scale the facility used for resident weights was struck by lightning. A facility policy, undated and titled "Weights", indicated for the facility to obtain resident weights at least once each month. 2) The clinical record for Resident #4 was reviewed on 9/17/14 at 2:05 p.m. The diagnoses for Resident #4 included, but were not limited to, diabetes mellitus, hypertension, and depression. Resident #4 was admitted on 8/1/14. A review of a Monthly Vital Sign and Weight Record document indicated a weight on 9/5/14 of 203 pounds. No other weights were located on this document and an admission weight was not located in other section of the clinical record, including on the Nurse's Admission Record or in the Nurse's Notes. The admission weight was requested from the Wellness Director on			

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	9/17/14 at 2:30 p.m. During an interview with LPN #1, on 9/17/14 at 2:48 p.m., LPN #1 indicated the facility did not have a working scale until about a week ago, since the facility scale was broken earlier in the summer. LPN #1 further indicated Resident #4 probably doesn't have an admission weight since she was admitted in August. On 9/18/14 at 9:46 a.m., the Wellness Director indicated the facility's scale was "fried" during a lighting storm at the end of July and the facility replaced the scale about a week ago. The Wellness Director further indicated she was unsure if Resident #4 had an admission weight. An admission weight for Resident #4 was requested again at this time. An admission weight for Resident #4 was not received by the time of final exit on 9/18/14 at 2:50 p.m.			
R000240	410 IAC 16.2-5-4(d) Health Services - Deficiency (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on observation, interview, and record review, the facility failed to provide a resident with needed	R000240	Resident #1 has been placed on the secure memory care unit All residents will be reviewed by a BSW to include their service plans to ensure they have been	10/18/2014

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	supervision for 1 of 5 residents reviewed. (Resident #1) Findings include: The clinical record for Resident #1 was reviewed on 9/17/14 at 11:30 a.m. The diagnoses for Resident #1 included, but were not limited to, memory loss and dementia. The 1/16/14 Mini-Mental Status Exam for Resident #1 indicated she was unaware of the year, the season, the date, the day, or the current month. It indicated, she was unaware of the town, state or country she was in. It indicated she did not know what floor she was on, or what building she was in. The exam indicated Resident #1's mental status was moderately impaired. A tour of the facility was conducted with the AD (Activity Director) on 9/17/14 at 10:45 a.m. The AD indicated the facility had 4 floors, and the 2nd floor was a locked unit. During the 2nd floor tour, Resident #1 was observed with her dog, and indicated she could not find her room. The AD redirected Resident #1 back to her room on the 3rd floor. Afterwards, the AD indicated, "She (Resident #1) is upset with us right now, because she thinks she got locked out of		properly placed in the Assisted Living or Memory Care unit The Wellness Director will review all new admissions information prior to admission to ensure that they are placed in the correct setting Service plans will be reviewed by the Wellness Director at least quarterly to ensure that existing residents are also placed in the correct setting Community staff will be educated on the safety of a memory impaired resident by the Wellness Director or designee Threshold for compliance on the proper placement of residents within the community is 95% If this threshold is not met after 6 months than continued monitoring will occur This system will be reviewed through the Quality Assurance process on an on-going basis	

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	the building this morning. I saw the whole thing. She went out one door, then had to come in another. I was pulling up at the time. She gets pretty confused." An interview was conducted with the AD on 9/17/14 at 2:45 p.m., to clarify whether Resident #1 was locked out of the facility that morning. The AD indicated, "She goes out the side door by herself every morning with her dog. No one goes with her, but we know where she is. This morning, the nurses knew she left, because she always leaves in the morning to walk her dog. She is confused, and thought she couldn't get back in this morning. She couldn't get back in because the front doors don't open until 8:00 a.m." Regarding whether Resident #1 went outside every morning before 8:00 a.m., she indicated, "Sometimes she goes out before 8:00 a.m., and sometimes after. The nurses know she's outside, but she's not supervised." The nurses notes for Resident #1 indicated the following: 7/15/14..."When elevator stopped on 2nd floor for another resident, this resident got off (symbol for "and") began walking down hall. When asked where she was going, resident stated, 'This is my floor.			

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	My room is down there.' Redirected to right floor and room." 7/21/14..."Reported to this writer by office staff that resident came down to front desk (symbol for "and") not sure where she was at." 7/21/14..."Res (resident) became disoriented (symbol for "after") leaving MDR (main dining room) to go to BR (bathroom). Unable to find way back to MDR. Res was located on 2nd floor by CNA (Certified Nurse Aide)." 8/9/14, 3:00 a.m...."Heard footsteps on 3rd floor while on second floor- upon getting on elevator - Resident on elevator looking for niece to take her to her appt (appointment). Resident given correct time (symbol for "and") redirected." 8/17/14..."Resident left DR (dining room) to get glasses. When no return she was found on 2nd floor & had not gotten to own room. She stated, 'I don't know what I'm doing.' Taken to room and returned to MDR for meal." 8/20/14..."Resident standing in front of elevator when door opened. Very upset, agitated d/t (due to) dog being walked too long by another resident. Cursing & yelling."			

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	8/21/14..." Resident standing in front of elevator when door opened on 2nd floor. Began yelling 'Where were you? I'm locked in here.' Very agitated. When asked why she was here & where she intended to go, became more agitated (symbol for "and") stated, 'I don't know anything about this damn place or what I'm doing.' Resident escorted back to room (symbol for "and") reassured." 9/9/14..."Resident on 2nd floor (symbol for "with") pet. Became very agitated when asked why back on 2nd floor. This was third time she got off on floor (symbol for "with") pet in about 20 min (minutes). Resident yelled @ this writer, 'No one f***ing helps me,' and began to cry. Resident escorted back to room..." 9/10/14..."Discussed (symbol for "with") family in regards to concerns of (symbol for "increased") confusion & agitation that resident has been displaying throughout stay in community. It is agreed between POA (power of attorney) & DON (Director of Nursing) of need to move resident in Memory Care unit (symbol for "with") her pet by 9/28/14. POA prefers for me to notify resident, and she will follow up on." This note was written by the DON.			

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	An interview was conducted with the DON on 9/17/14 at 1:40 p.m., regarding the 9/10/14 nurses note and the reason for waiting until 9/28/14 to move Resident #1 to the Memory Care Unit. She indicated, "My suggestion was before the next billing cycle because of the rate difference." Regarding a plan for needed supervision in the meantime, she indicated, "In the meantime, we redirect, but she doesn't wander off site." A tour of the outside of the facility was taken on 9/17/14 at 2:00 p.m. A retention pond, an interstate, and a home improvement store lumber yard with stacks of concrete bricks and lumber was observed in close walking proximity to the exit door Resident #1 was indicated as having left from every morning to walk her dog.			
R000247	410 IAC 16.2-5-4(e)(7) Health Services - Deficiency (7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident. Based on interview and record review, the facility failed to notify a Physician that a Resident did not receive her anti-depressant medication daily. This	R000247	Resident #4 received her medication without being medically compromised Physician was notified All residents medications and MAR will be reviewed by the Wellness	10/18/2014

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	affected 1 of 7 residents reviewed. (Resident #4) Findings include: The clinical record for Resident #4 was reviewed on 9/17/14 at 2:05 p.m. The diagnoses for Resident #4 included, but were not limited to, diabetes mellitus, hypertension, and depression. A review of Resident #4's Admission Orders, indicated an order for Celexa (anti-depressant medication) 10 mg (milligrams) daily for depression. A review of Resident #4's August MAR (Medication Administration Record) indicated Resident #4 did not receive her Celexa on 8/6/14 and 8/7/14 because the medication was unavailable. Physician notification of the missed doses of Celexa was not located in the clinical record. During an interview with the Wellness Director, on 9/18/14 at 10:26 a.m., she indicated it was the facility's policy to notify the Physician after a Resident missed a medication 3 times in a row. The Wellness Director further indicated anti-depression medication needed to be given as ordered/daily to be effective. The policy related to notifying the		Director or designee to ensure there are no other issues As per the policy medications are to be reordered three to four days in advance of need, to assure an adequate supply is on hand Notify the MD/designee when a missed dose occurs that can potentially compromise resident's welfare and monitor for effects MD/designee may chose to order an alternate medication and thus give the nursing staff the order to do so Nursing staff will be educated on the proper procedures for re-ordering of medications and physician notification regarding medication issues by the Wellness Director or designee The Wellness Director or designee will review at least two times per week for 30 days and then weekly for 30 days Threshold for compliance is 95% accuracy If this threshold in not met after two months than continued monitoring will occur This system will be reviewed through the Quality Assurance process on an on-going basis	

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	Physician regarding missed doses of medication was requested at this time. On 9/18/14 at 10:41 a.m., LPN #1 indicated anti-depression medication needed to given daily for the medication to be effective. LPN #1 further indicated it was the facility's policy not to notify the Physician about missed doses of an anti-depressant, until a Resident missed the medication 3 times in a row. "What Is The Most Important Information I Should Know About Celexa," (1/13) was retrieved on 9/18/14 at 12:57 p.m., from the National Alliance on Mental Illness (NAMI.org) website. The guidance indicated, "...Missing doses of citalopram [Celexa] may increase your risk for relapse in your symptoms...." The Wellness Director indicated, 9/18/14 at 2:32 p.m., she was unable to locate a specific policy related to a Resident missing 3 doses of a medication in row, before the Physician was to be notified. The Wellness Director further indicated it was a "general rule" of 3 consecutive missed medication doses before the Physician was to be notified.			
R000273	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and			

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	local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to ensure kitchen staff kept their facial hair restrained while in the kitchen. This had the potential to affect 9 of 9 residents in the facility who eat food from the kitchen. Findings include: An observation of the kitchen was made on 9/17/14 at 11:07 a.m. The DM (Dietary Manager) was observed with a beard and no beard cover working at the counter. Cook #5 was observed with facial hair on his chin, uncovered, cooking over the stove. An interview was conducted with the DM on 9/18/14 at 11:00 a.m., regarding he and Cook #5 not having their facial hair covered while in the kitchen the previous day. He indicated, "It was an accident." An interview was conducted with the DM on 9/18/14 at 12:30 p.m., regarding a policy for restraining facial hair in the kitchen. He indicated, "We don't have a policy for beard nets. We are a start up company, so we don't have a policy for a lot of things. I can come up with one	R000273	Facial hair is being properly restrained within the kitchen Food service staff will be educated on the policy regarding facial hair restraints by the DM or designee The DM or designee will make at least weekly rounds to ensure proper hair restraints are being used for 30 days Threshold for compliance is 95% accuracy If this threshold is not met after 30 days than continued monitoring will occur This issue will be reviewed in the Quality Assurance process on an on-going basis	10/18/2014

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CROWN SENIOR LIVING	7960 SHADELAND AVENUE NORTH INDIANAPOLIS, IN 46250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	today." The DM provided a copy of the Hair Restrains Policy effective 9/18/14 on 9/18/14 at 1:07 p.m. It indicated, "Hair that cannot be effectively restrained by a hat or cap must wear a hairnet."			
R000297	410 IAC 16.2-5-6(c)(1) Pharmaceutical Services - Noncompliance (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana. Based on interview and record review, the facility failed to ensure the pharmacy delivered medication in a timely manner. This affected 1 of 7 residents reviewed. (Resident #4) Findings include: The clinical record for Resident #4 was reviewed on 9/17/14 at 2:05 p.m. The diagnoses for Resident #4 included, but were not limited to, diabetes mellitus, hypertension, and depression. Resident #4 was admitted on 8/1/14. A review of Resident #4's Admission Orders, indicated an order for Celexa	R000297	Resident #4 received her medication without being medically compromised Physician was notified All residents medications and MAR will be reviewed by the Wellness Director or designee to ensure there are no other issues As per the policy medications are to be reordered three to four days in advance of need, to assure an adequate supply is on hand Notify the MD/designee when a missed dose occurs that can potentially compromise resident's welfare and monitor for effects MD/designee may chose to order an alternate medication and thus give the nursing staff the order to do so Nursing staff will be educated on the proper procedures for re-ordering of	10/18/2014

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	(anti-depressant medication) 10 mg (milligrams) daily for depression. A review of the August MAR (Medication Administration Record) indicated Resident #4 did not receive her Celexa on 8/6/14 and 8/7/14 because the medication was unavailable. In a policy, titled Ordering Medication from the Pharmacy, no date, was received from the Wellness Director on 9/18/14 at 12:21 p.m. The policy indicated, "...Medications and related products are received from the pharmacy supplier on [sic] a timely basis....10. New medications, except for emergency or stat medications, are ordered as follows: 11a. If needed before the next regular delivery, phone the medication order to the pharmacy immediately upon receipt. Inform the pharmacy of the need for prompt delivery and request delivery within a reasonable time. 12b. [sic] Require timely delivery of new orders so that medication administration is not delayed...." During an interview with the Wellness Director, on 9/18/14 at 1:10 p.m., the Wellness Director indicated Resident #4 did not receive the Celexa on 8/6/14 and 8/7/14 because the medication was not received from the pharmacy yet. The		medications and physician notification regarding medication issues by the Wellness Director or designee The Wellness Director or designee will review at least two times per week for 30 days and then weekly for 30 days Threshold for compliance is 95% accuracy If this threshold in not met after two months than continued monitoring will occur This system will be reviewed through the Quality Assurance process on an on-going basis	

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	Wellness Director further indicated the facility notifies the pharmacy of new admission with the the Resident's Physician's Orders and the number of doses the Resident had from home before the medication was needed. On 9/18/14 at 2:18 p.m., the Wellness Director indicated the Facility sends the Resident's information/orders on the day of a Resident's admission. The Wellness Director further indicated Resident #4 had Celexa that she brought with her and the pharmacy was notified of how many doses she had.			
R000301	410 IAC 16.2-5-6(c)(5) Pharmaceutical Services - Deficiency (5) Labeling of prescription drugs shall include the following: (A) Resident ' s full name. (B) Physician ' s name. (C) Prescription number. (D) Name and strength of the drug. (E) Directions for use. (F) Date of issue and expiration date (when applicable). (G) Name and address of the pharmacy that filled the prescription. If medication is packaged in a unit dose, reasonable variations that comply with the acceptable pharmaceutical procedures are permitted. Based on interview and record review, the facility failed to ensure opened insulin flexpens (multi-dose applicator)	R000301	Resident #5 and #7 have date of opening on their Humalog Flexpen There is no indication of any medical concerns based on this information	10/18/2014

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	had an open date on them. This affected 2 of 3 residents that received insulin from the third floor refrigerator. (Resident #5 and Resident #7) Findings include: During an observation of the medication refrigerator on the facility's third floor with LPN #1, on 9/18/14 at 11:27 a.m., a used Humalog (insulin) flexpen (mulitdose applicator) for Resident #5 and a used Novolog (insulin) flexpen for Resident #7 were noted in the medication refrigerator. A date was not located on either flexpen of when it was opened. During an interview with LPN #1, on 9/18/14 at 11:27 a.m., she indicated both flexpens had just been used recently. LPN #1 further indicated she was unsure of when the insulin flexpens were opened, so she will discard both flexpens. LPN #1 also indicated the flexpens should have an open date on them. A review of the September MAR (Medication Administration Record) for Resident #5, indicated Resident #5 last received her Humalog on 9/18/14 at breakfast. A review of the September MAR for Resident #7 indicated Resident #7 last		The Wellness Director or designee will review all insulin for the appropriate labeling Nursing staff will be educated on the policy concerning Infusion therapy product administrator The Wellness Director or designee will review at least two times a week for 30 days and then weekly for an additional 30 days for the appropriate date opening initials on multidose vials This system will be reviewed through the Quality Assurance process on an on-going basis	

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	received his Novolog on 9/17/14 with dinner. A policy titled, Infusion Therapy Product Administration, no date, was received on 9/18/14 at 1:18 p.m., from the Wellness Director. The policy indicated, "...2. The date opened and the initials of the first person to use the vial are recorded on mulitdose vials...."			